Health Home Care Coordinators Training

Comprehensive Care Management

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Today's Presenter

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The Six Health Home Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

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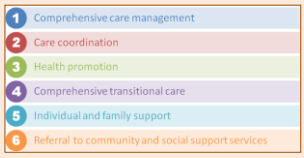
Comprehensive Care Management

Comprehensive Care Management can be provided in combination with any of the other five services



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Purpose:

Describe the activities that constitute Comprehensive Care Management

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Learning Objectives

- Examine the activities included in comprehensive care management
- Define Tier 1 services
- Discuss health action planning as it pertains to comprehensive care coordination

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Your Value as a Care Coordinator (CC)

- CCs have a unique understanding of the communities they serve
  - Including an awareness of its culture, language, ethnicity, and values
    - Established relationships with local providers and services

Resource from the Basic Training Manual

The Health Home Services

1. Comprehensive Care Management

Care Coordinators will deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services must include state approved screens, demonstrate the ability to provide continuity and coordination of care through in-person visits, and the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning.

Screens include clinical, functional screens, including depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual. Screens will support referrals to services when needed, e.g., referral for assessment of need for chemical dependency treatment, specialty care or long-term services and supports. The beneficiary's activation level shall be reassessed every 6 months while receiving health home services.

Other screens and assessments that may supplement comprehensive care management are Medicaid managed care organizations' contractually required health risk assessments for enrollees with special health care needs, mental health treatment plans, chemical dependency treatment plans, and/or other pre-existing care plans which include assessment results.

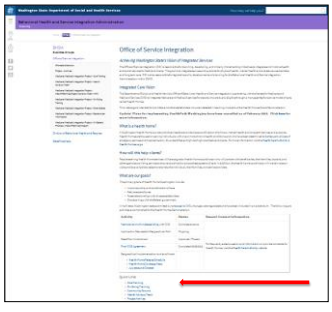
2. Care Coordination

The dedicated Health Home Care Coordinator shall play a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. The Care Coordinator shall assure communication is fostered between the providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health and long-term services and supports. Care Coordination is the bridge between all the beneficiary's systems of care, including non-clinical supports such as food, housing, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload will be maintained at a level that ensures fidelity in providing required health home services, including interventions. Community health workers, peer counselors or other non-clinical staff may be used to facilitate the work of the assigned Health Home Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and

DSHS Website



Office of Service Integration

https://www.dshs.wa.gov/bhsia/office-service-integration/office-service-integration

Service Tiers

Health Home Service Tiers

Comprehensive care management can be provided at all tiers

Tier 1	• Initial engagement and action planning
Tier 2	• Intensive level of care coordination
Tier 3	• Low level of care coordination

Tier 1 Activities

Must be completed within 90 days of referral to the Lead Organization and includes:

- Outreach and Engagement
  - Contacting by telephone and/or letter
  - Review of PRISM
- Face-to-face visit (required)
  - Introduce the client to Health Home Services
  - Assess the client's health and other needs
  - Confirm the client's agreement to participate

Tier 1 Activities (cont.)

Signed consent to participate and share information

Completion of required and optional screenings

Completion of the Goal Setting and Action Planning Worksheet (optional)

Tier 1 Activities (cont.)

Development of the Health Action Plan (HAP)

Periodic phone calls and visits as needed

Document activities

May be billed one time only

1 Comprehensive Care Management

1. Begins with assessment
   - Review of PRISM (Predictive Risk Intelligence SysteM)
   - Review of other existing database information
     - CARE, medical records, etc.

1 Comprehensive Care Management

2. Outreach and engagement
   - Initial outreach may include:
     - Telephone outreach
       - May be completed by other staff including clerical support staff, community health workers, peer support specialists, case managers for other programs
     - Scheduling a face-to-face visit

1 Comprehensive Care Management

3. Provides in-person periodic follow-up using face-to-face visits and telephone calls
4. Includes state approved required and optional screenings and assessments

1 Comprehensive Care Management (cont.)

5. Assesses beneficiary readiness for self-management and promotes self-management skills so the beneficiary is better able to engage with health and service providers

1 Comprehensive Care Management (cont.)

6. Monthly contacts:
   - Provide continuity of care
   - Support the achievement of self-directed health goals
   - Improve functional or health status, or prevent or slow declines in functioning

1 Comprehensive Care Management (cont.)

7. Coordinate care transitions:
   - From hospitals
   - Nursing facilities
   - Other institutions

1 Comprehensive Care Management (cont.)

8. Coordination of primary care:
   - Work with PCP and other members of the client's health team to coordinate services
   - Identify gaps in services and assist with meeting other needs such as dental and vision

1 Comprehensive Care Management (cont.)

9. Provision of other core services:
   - Comprehensive care transitions
   - Promotion of health literacy and education
   - Referral to LTSS and other social services
   - Health promotion and coaching
   - Individual and family support
   - Referral to community and social support services

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1 Comprehensive Care Management (cont.)

10. Create a relapse plan or crisis plan:
   - One of our roles is to coach and model how to handle medical and other crisis during evenings and weekends

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Moving Toward Health Action Planning

Consider the clients responses by reviewing and discussing the activation measure, required screenings, and optional screenings

Responses may provide a clue as to changes the client would like to make

Consider using the Goals Setting and Action Planning Worksheet

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Goal Setting and Action Planning Worksheet

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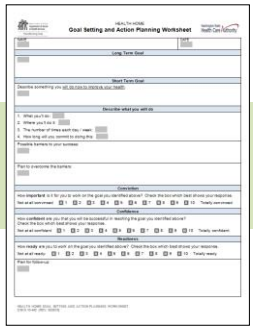
A Tool for Starting the Conversation

Goal Setting and Action Planning Worksheet



Coaching and Action Planning

Goal Setting and Action Planning Worksheet

- Start where the individual is
- Determine what the individual wants to change
- The action plan is negotiated and is based on the client's level of activation

Coaching and Action Planning (cont.)

Goal Setting and Action Planning Worksheet

- The action plan is something achievable given the individual's level of activation
- At Levels 1 and 2 action plans focus on knowledge, belief, awareness, and pre-behaviors
- At Levels 3 and 4 action plans focus on the initiation of new behaviors and maintaining behaviors

Goal Setting and Action Planning Worksheet

What has your experience been using the worksheet?

Are their particular types of clients that you have found that it works best with?

Do you leave it with the client or mail a copy?

How have you used it to transfer it to the HAP?

Developing an Action Plan

Coach the client to select the Action Steps with the least number of barriers and prioritize them.

Save the list of Action Steps so alternatives can be tried if the first ones are not successful; reassure client that many problems are not easily solved and may take time and multiple approaches.

Develop Action Steps

Describe

- *What* the client has agreed to do
- *What* the Care Coordinator has agreed to do
- *Where* they will do it
- How *often*(each day/week)?
- For how *long*?

Consider the Client

1. How important is the goal?
2. How confident is the client?
3. How ready is the client?

Coaching and the Health Action Plan

Use your "Coaching for Activation " Training and professional skills to guide the individual to:

- Appropriate choices
- Attainable goals
- Action steps
- Improved health

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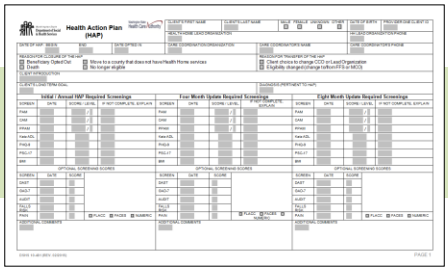
Health Action Planning

The Health Action Plan


Health Action Plan (HAP)

HAP Instructions

The Health Action Plan (HAP)

Establishes:

- ✓ Client and Care Coordinator identified:
  - ✓ Long term goal
  - ✓ Short term goal/s
  - ✓ Action steps

Health Action Planning

Fostering hope is the most important element of coaching and planning

Help the individual engage in their health and their healthcare by taking an active role in the process

Key Skills for Health Action Planning

Demonstrate a positive belief in the individual's ability to accomplish appropriate goals and action steps

Emphasize stress management and coping skills

Key Skills for Health Action Planning

Active and reflective listening

Guiding; not directing

Gain understanding of individual's values and priorities

Helping each individual identify strengths, abilities, and successes

Collaborate to improve self-efficacy and capacity

Elicit

- Elicit the client's story
- Build rapport
- Obtain a behavioral history, including past attempts to change behavior
- Identify barriers
  - Use open ended questions
  - Focus on feelings
  - Use reflections

Analyze!

What do you think drives poor health and high costs for your client?

Consider:

- Client's perspective
- Results from assessment and screening tools
- PRISM data
- Patient Activation Measures

Explore Barriers

- Ambivalence?
- Understanding?
- Support system?
- Energy levels/sleep quality/pain?
- Depression?
- Health literacy?
- Financial?
- Confidence?
- Social Isolation?

Client-centered Practice and Client Directed Care

Consider how much risk the client is willing to assume
- What can you suggest to mitigate the risk?

What is the client's ability to make decisions?
- What is the role of collaterals?

How much can the client direct their services?

What can you do to empower the client?

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Screenings

Required Screenings

Enter the dates and scores of the screening on the HAP

- PHQ-9 – Patient Health Questionnaire (Depression Screening) or
- Pediatric Symptom Checklist – 17 (PSC-17) (ages 4-17)
- BMI – Body Mass Index
- Katz Activities of Daily Living
- Patient Activation Measure
  - Patient Activation Measure (PAM) or
  - Caregiver Activation Measure (CAM) or
  - Parent Patient Activation Measure (PPAM)

Optional Screenings

Enter the dates and scores of the screenings on the HAP

- DAST – Drug Abuse Screening
- GAD-7 – Generalized Anxiety Disorder 7 item scale
- AUDIT – Alcohol Use Disorders Identification
- Falls Risk – Standardized measure of falls risk
- Pain Scales – Administration of appropriate pain scale

Four Month Updates

Four Month Review

- Administration of the required screenings
- Administration of clinically indicated optional screenings
- Reviewing and updating the HAP
- Care coordination and other Health Home services

Health Home Tiers

Tier **One**	Tier **Two**	Tier **Three**
Initial engagement and action planning	Intensive level of care coordination	Low level of care coordination

Tier Two Services

- ✓ Tier One may be billed only once
- ✓ Four month updates to provide comprehensive care management is then billed as a Tier 2

Getting Support

Working with allied and affiliated staff:

- Outreach specialists
- Peer support specialists
- Community connectors
- Community health workers
- Medical leads
- Case aides
- Wellness coaches

Summary

Bringing it all together

Important Takeaways

Assessment is a continuing process

The Health Action Plan is a living fluid document

Ensure that all activities are client-centered

When documenting consider which of the six services you are providing

Complete required screenings

Consider which optional screenings are clinically indicated

Informational Websites

Health Care Authority:
http://www.hca.wa.gov/Pages/health_homes.aspx

DSHS Health Homes:
https://www.dshs.wa.gov/bhsia/office-service-integration/office-service-integration

Need further information?

Check with your Lead Organization

E-mail your questions to:
Health Care Authority:
HealthHomes@HCA.wa.gov

Contact Information

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Join Us

– Next Webinar

– Thursday, May 14, 2015
– 9:00 AM – 10:30 AM
– Topic: Care Coordination

– Make your reservation now at:

https://attendee.gotowebinar.com/rt/2336104130912005121

Post Webinar Discussion

- What techniques have you used to engage the client to complete the required and optional screenings?
- What experience have you had using the Goal Setting and Action Planning Worksheet? Is it helpful?
- How do you manage your caseload? What techniques or tools do you use to remind you to make periodic contacts and visits to your clients?
- What types of affiliated staff do you use with care coordination? Do you work with any of the following: outreach specialists, community health workers, peer support specialists, community connectors, wellness coaches?

Certificate of Completion

Comprehensive Care Management

presented by Cathy McAvoy, MPA
Health Homes Program Manager
Integration Services - DSHS

Webinar aired on: April 9, 2015 in Lacey, Washington
for Health Home Care Coordinators

Please sign and date this slide to attest that you attended this training Webinar

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